

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

### **I. DISPUTE**

1. a. Whether there should be reimbursement of \$791.00 for dates of service 08/31/01, 09/07/01, and 09/10/01.
- b. The request was received on 03/15/02.

### **II. EXHIBITS**

1. Requestor, Exhibit I:
  - a. TWCC 60 and Response to a Request for Dispute Resolution dated 05/14/02
  - b. HCFA(s)
  - c. EOBs from other carriers
  - d. Medical Records
  - e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
2. Respondent, Exhibit II:
  - a. TWCC 60
  - b. HCFA(s)
  - c. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
3. The Carrier and the Provider have three day responses in the dispute packet, also there is not a signed sheet by the Carrier. All of the information submitted in the case file will be reviewed, and a decision will be rendered on this.

### **III. PARTIES' POSITIONS**

1. Requestor:

The Requestor did not have a position statement in the case file submitted.
2. Respondent:

“The request fails to provide the information required by TWCC Rule 133.307(e)(1)(B) in that the provider supplies no convincing evidence that the carrier ever received bills for the DOS in question that would have permitted the creation of EOBs.”

#### IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are 08/31/01, 09/07/01, and 09/10/01.
2. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT	BILLED	PAID	EOB Denial Code(s)	MARS	REFERENCE	RATIONALE:
08/31/01	99080-73	\$15.00	\$0.00	No EOB	DOP	TWCC Rule 129.5(i)	<b>F-“Reduction according to the Fee Guideline.”</b> “Notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy. The amount of reimbursement shall be \$15.00. Therefore, reimbursement in the amount of <b>\$15.00 is recommended.</b> ”
08/31/01	99204	\$106.00	\$0.00	No EOB	\$106.00	MFG E/M (IV)(C)(2) CPT descriptor	“Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history; a comprehensive examination; medical decision making of moderate complexity.” The medical documentation submitted for the office visit in dispute, indicates that all of three key components were met or exceeded per the MFG. Therefore, reimbursement <b>is recommended</b> in the amount of <b>\$106.00.</b> ”
09/07/01	97750-FC	\$500.00	\$0.00	No EOB	\$100.00 (per hour)	MFG MGR (I) (E)(2)	“FCEs are allowed a maximum of three times for each injured worker. FCEs shall be billed as code 97750-FC. FCEs shall be reimbursed at \$100.00 per hour for a maximum of five hours (\$500.00) for the initial test and two hours (\$200.00) for an interim and/or discharge test. A summary report for each FCE is required and shall not be reimbursed in addition to the evaluation charge. Required documentation includes the start and end time for the FCE.” The medical documentation indicates that the services were rendered and the start and end time is documented on the last page of the report from start time of 8:00 AM to end time of 1:00 pm. The provider followed the referenced rule and therefore, reimbursement is recommended in the amount of <b>\$500.00.</b> ”
09/10/01	99214	\$71.00	\$0.00	No EOB	\$71.00	MFG E/M (IV)(C)(2) CPT descriptor	“Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed history; a detailed examination; medical decision making of moderate complexity.” The medical documentation submitted for the office visit in dispute, indicates that all of three key components were met or exceeded per the MFG. Therefore, reimbursement <b>is recommended</b> in the amount of <b>\$71.00.</b> ”

09/10/01	97265	\$43.00	\$0.00	No EOB	\$43.00	MGR (I)(A)(10); CPT Descriptor	Medical documentation indicates that the services were rendered and billed according to the CPT descriptor. Therefore, reimbursement is recommended in the amount of <b>\$43.00</b> .
09/10/01	97124	\$56.00	\$0.00	No EOB	\$28.00 (per 15 minutes)	MGR (I)(A)(10); CPT Descriptor	Medical documentation indicates that the services were rendered and billed according to the CPT descriptor. Therefore, reimbursement is recommended in the amount of <b>\$56.00</b> for one body area.
<b>Totals</b>		\$791.00	\$0.00				The Requestor is entitled to reimbursement in the amount of <b>\$791.00</b> .

## VI. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit \$791.00 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 1st day of July 2002.

Michael Bucklin, LVN  
Medical Dispute Resolution Officer  
Medical Review Division

MB/mb

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and re-delegated by Virginia May, Deputy Executive Director.